

200% FPL
FAMILY PLANNING AND REPRODUCTIVE HEALTH
DETERMINATION OF CLIENT ELIGIBILITY FOR STATE FUNDED SURGICAL SERVICES
Effective April 1, 2003

Client Name _____ Client ID Number _____

Date of Visit _____ Date of Birth _____ Age _____

Gross Monthly Income _____ Family Size _____

Family Size	1	2	3	4	5	6	7	8	Each Additional Person
Maximum* Monthly Income	\$1,496	\$2,020	\$2,544	\$3,066	\$3,590	\$4,114	\$4,636	\$5,160	\$262

SERVICE CLIENT IS ELIGIBLE FOR _____

FROM _____ **TO** _____

"I am not covered by a private insurance or Title XIX (Public Assistance) plan which covers this service."

"I have been offered a written statement of the results of this eligibility determination."

"I hereby agree that all facts stated above are true and accurate to the best of my knowledge."

Client's Signature

Date

Witness' Signature

Date

CLIENT ELIGIBILITY DETERMINATION FOR NEW SERVICE
WHEN FAMILY SIZE AND INCOME HAVE NOT CHANGED

SERVICE CLIENT IS ELIGIBLE FOR _____

ELIGIBILITY PERIOD FROM _____ **TO** _____

"My family size and income have not changed since the last eligibility determination."

Client's Signature

Date

Witness' Signature

Date

Eligibility for state funded services does not guarantee/ensure that services will be provided with those funds. Provision of service with state funds is dependent upon availability of funds.

*** Instructions for computing monthly income and completing this form are on the back.**

